GLOSSARY

This is a list of abbreviations, acronyms, and definitions used in the Adult Day Health Care (ADHC) Waiver Manual Chapter.

Abuse –The infliction of physical or mental injury, or actions which may reasonably be expected to inflict physical injury, on a recipient by other parties, including but not limited to such means as sexual abuse, abandonment, isolation, exploitation, or extortion of funds or other things of value (La. R.S. 15.1503)

Abuse of Medicaid Funds – Inappropriate use of public funds by either providers or recipients, including practices which are not criminal acts and which may even be technically legal, but which still represent the inappropriate use of public funds.

Activities of Daily Living (ADL) – The functions or basic self-care tasks which are performed by an individual in a typical day, either independently or with supervision/assistance for mobility. Activities of daily living include bathing, dressing, eating, grooming, walking, transferring and/or toileting. The extent to which a person requires assistance to perform one or more of these activities often is a level of care criterion.

Adult Day Health Care (ADHC) – A medical model Adult Day Health Care program designed to provide services for medical, nursing, social, and personal care needs to adults who have physical, mental or functional impairments. Such services are rendered by utilizing licensed professionals in a community based nursing center.

Adult Day Health Care Center – Any place owned or operated for profit or nonprofit by a person, society, agency, corporation, institution, or any group wherein two or more functionally impaired adults who are not related to the owner or operator of such agency are provided with adult day health care services. This center type will be open and providing services at least five continuous hours in a 24-hour day for at least five days a week.

Adult Day Health Care (ADHC) Waiver – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to individuals who: are age 65 or older, or aged 22-64 and have a physical disability, and meet nursing facility level of care requirements.

Advocacy –The process of assuring that recipients receive appropriate high quality supports and services and locating additional services needed by recipients which are not readily available in the community.

Allegation of non-compliance – A claim that an event has occurred or is occurring that has the potential for causing no more than minimal harm to a recipient or recipients. (La. R.S. 40:2009.14)

Allowable Cost – Those expenses incurred by providers to conform to state licensure and federal certification standards. General cost principles are applied during the desk review and audit process to determine allowable costs.

Appeal – A request for a fair hearing concerning a proposed agency action, a completed agency action, or failure of the agency to make a timely determination; A legal proceeding in which the applicant/enrollee and OAAS representative, or designee, presents the case being appealed in front of an impartial hearing officer. (see Fair Hearing.)

Applicant – An individual who is requesting Medicaid Waiver services.

Assessment – One or more processes that are used to obtain information about an individual, including his/her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that an individual meets nursing facility level of care and requires waiver services. The results are used to develop the Plan of Care and an Individualized Service Plan.

Bureau of Health Services Financing (BHSF) – The Bureau within the Louisiana Department of Health is responsible for the administration of the Medicaid program and is the administering agency for the OAAS Waiver programs.

Case Management – (See Support Coordination)

Center for Medicare and Medicaid Services (CMS) – The agency in the Department of Health and Human Services (DHHS) responsible for federal administration of the Medicaid and Medicare programs.

Community Choices Waiver – An optional Medicaid program under section 1915 (c) of the Social Security Act that provides services in the community as an alternative to institutional care to individuals who: are age 65 or older, or aged 21-64 and have a physical disability, and meet nursing facility level of care requirements.

Complaint – An allegation that an event has occurred or is occurring and has the potential for causing more than minimal harm to a recipient. (La. R.S. 40:2009.14).

Confidentiality – The process of protecting a recipient's or an employee's personal information as required by the Health Insurance Portability and Accountability Act (HIPAA).

Corrective Action Plan – Written description of action a provider plans to take to correct identified deficiencies.

Department of Health and Human Services (DHHS) – The federal agency responsible for administering the Medicaid Program and public health programs.

Direct Care Staff – Unlicensed staff paid to provide personal care or other direct service and support to qualified waiver recipients to enhance their well-being, and who are involved in face-to-face direct contact with the participant.

Eligibility – The determination of whether or not a recipient qualifies to receive waiver services based on meeting established criteria as set by LDH.

Enrollment – A determination made by LDH that a provider or agency meets the necessary requirements to participate as a Medicaid provider This is also referred to as provider enrollment or certification.

Exploitation – The illegal or improper use or management of the funds, assets, or property of a person who is aged or an adult with a disability, or the use of power of attorney or guardianship of a person who is aged or an adult with a disability for one's own profit or advantage. (La. R.S. 15:1503)

Extortion – The acquisition of a thing of value from an unwilling or reluctant adult by physical force, intimidation, or abuse of legal or official authority. (La. R.S. 15:1503)

Electronic Visit Verification (EVV) – A web-based system that electronically records and documents the precise date, start and end times that services are provided to recipients. The EVV system will ensure that recipients are receiving services authorized in their POCs, reduce inappropriate billing/payment, safeguard against fraud and improve program oversight.

Fair Hearing – A legal proceeding in which the recipient and OAAS representative, or designee, presents the case being appealed in front of an impartial hearing officer.

Fiscal Intermediary – The contractor, managed by Medicaid, which processes claims, issues payments to providers and agencies, handles provider inquiries and complaints, provides training for providers

Follow-Up – A core element of service delivery to the recipient that includes oversight and monitoring of the provision of services, ongoing assessment and mitigation of health, behavioral and personal safety risk, and crisis management.

Formal Services – Another term for professional and paid services.

Good Cause – An acceptable reason to change agencies or providers outside of the designated circumstances and timelines.

Health Standards Section (HSS) – A section of the Louisiana Department of Health responsible for the licensure and ~~Medicaid providers~~ enforcement of compliance of those health care providers licensed by the Health Standards Section.

Home and Community-Based Services Waiver – An optional Medicaid program established under 1915(c) of the Social Security Act designed to provide services in the recipient's home or community as an alternative to institutional services to individuals who meet nursing facility level of care. Waiver services are approved by CMS and are limited to serving a specific number of individuals in accordance with the approved and available waiver opportunities.

Individualized Service Plan (ISP) – An individualized written plan of action to be completed and followed by the ADHC center to address the recipient's difficulties, health care needs, and services based upon his/her assessment.

Informal Services – Another term for non-professional or non-paid services provided by family, friends and community/social network.

Institutionalization – Placement of a recipient in any inpatient facility including, but not limited to a hospital , nursing facility, or psychiatric hospital.

Internal Quality Improvement – An ongoing process to objectively and systematically monitor and evaluate the quality of services provided to individuals served by Medicaid, to pursue opportunities to improve services, and to correct identified problems.

Legal Guardian – A person who has been granted custody of an individual by a court order.

Licensure – A determination by the Health Standards Section that a provider meets the requirements of State law to provide health care and services.

Linkage – Act of connecting a recipient to a specific support coordination agency or a provider.

Long Term-Personal Care Services (LT-PCS) – A Medicaid state plan service which provides assistance with ADL and IADL as an alternative to institutional care to qualified Medicaid recipients who are age 21 or older and meet specific program requirements.

Louisiana Department of Health (LDH) - The state agency responsible for administering the state's Medicaid Program and other health and related services including aging and adult services, public health, mental health, developmental disabilities, and behavioral health services.

Medicaid – A federal-state financed medical assistance program that is provided under a State Plan approved under Title XIX of the Social Security Act.

Medicaid Fraud – An act of any person with the intent to defraud the state through any medical assistance program created under the federal Social Security Act and administered by LDH or any other state agency. (LA RS 14:70.1)

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system for the Medicaid Program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible recipients.

Medicare – The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

Minimal Harm – An incident that causes no serious temporary or permanent physical or emotional damage and does not materially interfere with the recipient's activities of daily living. (La. R.S. 40:2009.14)

Neglect – The failure by a care giver responsible for an adult's care or by other parties to provide the proper or necessary support or medical, surgical, or any other care necessary for his/her well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be neglected or abused. (La. R.S. 15:1503)

Non-allowable costs – Costs that are not based on the reasonable cost of services covered under Medicare/Medicaid and are not related to the care of recipients.

Nursing Facility (NF) – A facility which meets the requirements of sections 1819 or 1919 (a) (b) (c) and (d) of the Social Security Act. A nursing facility provides intermediate, skilled nursing, and/or long term care for those individuals who meet the eligibility requirements.

Office of Aging and Adult Services (OAAS) – The office within the Louisiana Department of

Health that is responsible for the management and oversight of certain Medicaid home and community-based services waiver programs, state plan programs, adult protective services for adults ages 18 through 59, and other programs that offer services and supports to the elderly and adults with disabilities.

OAAS Regional Office – One of nine administrative offices within the Office of Aging and Adult Services.

Office of Behavioral Health (OBH) – The office in LDH that is responsible for services to individuals with behavioral or addictive disorders.

Office of Public Health (**OPH**) – The office in LDH responsible for personal and environmental health services.

Personal Outcome – Result achieved by or for the waiver recipient through the provision of services and supports that make a meaningful difference in the quality of the recipient's life.

Person-Centered – An approach used in the assessment and planning processes that considers an recipient's personal experiences and preferences.

Plan of Care (POC) – A written person-centered plan developed by the recipient, his/her responsible representative and support coordinator based on assessment results. The plan specifies services to be accessed and coordinated by the support coordinator on the recipient's behalf and includes long-range goals, assignment of responsibility, and time frames for completion or review by the support coordinator.

Program of All-Inclusive Care for the Elderly (PACE) – program which coordinates and provides all needed preventive, primary health, acute and long-term care services to qualified recipients age 55 and older in order to enhance their quality of life and allow them to continue to live in the community.

Progress Notes – Documentation of the delivery of services, activities and observations of a recipient to record progress toward the goals indicated in the POC and/or ISP.

Provider – An entity which delivers Medicaid services under a provider agreement with LDH.

Provider Agreement – A contract between the provider of services and the Medicaid program or other LDH office. The agreement specifies responsibilities with respect to the provision of services and payment under Medicaid or other LDH office.

Provider Enrollment – See " Enrollment".

Re-assessment – See "Assessment". The re-assessment is completed at least annually and when a significant status change occurs in order to update the POC and/or ISP.

Recipient – An individual who has been certified for Adult Day Health Care through a Medicaid Waiver program. A recipient may also be referred to as a participant.

Representative Payee – A person designated by the Social Security Administration to receive and disburse benefits in the best interest of and according to the needs of the Medicaid-eligible recipient.

Responsible Representative – An adult who has been designated by the recipient to act on his/her behalf with respect to his/her services. The written designation of a responsible representative does not give legal authority for that individual to independently handle the recipient's business without the recipient's involvement. In the case of an interdicted individual, the responsible party must be the curator appointed by the court of competent jurisdiction.

Request for Services Registry (RFSR) – A waiting list for the ADHC Waiver program which contains the names and dates of requests of individuals applying for an ADHC Waiver opportunity.

Self-neglect – The failure, either by the adult's action or inaction, to provide the proper or necessary support or medical, surgical, or any other care necessary for his own well-being. No adult who is being provided treatment in accordance with a recognized religious method of healing in lieu of medical treatment shall for that reason alone be considered to be self-neglected. (La. R.S. 15:1503)

Sexual abuse – Any non-consensual sexual activity between a recipient and another individual. Sexual activity includes, but is not limited to kissing, hugging, stroking, or fondling with sexual intent; oral sex or sexual intercourse; insertion of objects with sexual intent; request, suggestion, or encouragement by another person for the recipient to perform sex with any other person when recipient is not capable of or competent to refuse.

Support Coordination – Services provided to eligible recipients to help them gain access to the full range of needed services including medical, social, educational, housing, and other support services regardless of the funding source for these services. Activities also include assessment, Plan of Care development, service monitoring, critical incident management, and transition/discharge.

Support Coordinator – An individual who meets the required qualifications and who is employed by a Support Coordination Agency.

Transition – A shift from a recipient's current services to another appropriate level of services, including discharge from all services.

Waiver Opportunity – An offer made to an individual on the ADHC Waiver Request for Services Registry. Waiver opportunities are limited to a finite number of individuals each year as approved by the state legislature and CMS.